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June 2, 2010

Sally Jeffcoat
St Alphonsus Regional Medical Center
1055 North Curtis Road
Boise, ID 83706

FILE COPY

Provider #130007

Dear Ms. Jeffcoat:

On **May 18, 2010**, a complaint survey was conducted at St Alphonsus Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004634

Allegation #1: The hospital failed to respond to grievances.

Finding #1: An unannounced survey of the hospital was conducted 5/17/10 through 5/18/10. Ten medical records were reviewed, including those of six patients who had been discharged and four records of current patients. Grievance documentation and the grievance policy were reviewed. Staff and four current patients were interviewed.

The hospital's grievance policy was reviewed. The policy outlined the procedure to follow for a patient/family complaint. This procedure included gathering as much information as possible about the situation, assuring the complainant the concern will be investigated, and notifying the complainant of who the hospital contact will be and an indication of how the investigation will be conducted. The issues identified in complaints were forwarded to the appropriate location manager who was to ensure the investigation process was completed and appropriate actions taken. Once the investigation was complete, the patient/family was to be notified of the results and follow up actions taken.

The Patient Relations Supervisor was interviewed. She explained that a majority of complaints/grievances were investigated through the Patient Relations Department,

however if the allegation was of a more serious nature, i.e. involving patient death, harm, abuse, etc, it would be handled by Risk Management following the same process described above.

The Patient Relations Supervisor reviewed four grievances selected from the grievance log, all related to complaints of nursing care. Two of the grievances were recent and still under investigation by the appropriate departments. One grievance had been addressed and the appropriate follow up letter had been sent to the complainant.

One grievance in the grievance log documented an investigated by Risk Management. The Patient Relations Supervisor discussed her involvement in this case during an interview. She stated the complainant arrived at the facility on 11/06/09 and was introduced to the Patient Relations Supervisor. She escorted him to a room for privacy and was presented a letter originally sent to the hospital on 7/18/09. She listened to his concerns and realized he had already met with Risk Management regarding the grievance. She offered to locate the hospital contact assigned to the investigation, however, the complainant declined the offer.

This grievance was reviewed with Risk Management. Documentation was provided showing a timeline of events, including the investigation and correspondence. The complaint letter was received on 7/22/09, and by 7/24/09 two members from Risk Management met with the complainant and sent the complainant a letter following the meeting. In addition, by 7/24/09, nine hospital staff had been alerted to the complaint and several individuals had been delegated investigation responsibilities. Once the medical record was complete with all pending dictation, etc, it was sent for peer review. This process caused the investigation to take longer than originally reported to the complainant. There was documentation of a phone call between the hospital contact and the complainant of 12/04/09. At that time the complainant stated he had retained legal representation, and the hospital should have received a letter from that attorney. The complainant was informed the hospital had not received a letter from the attorney but would await further communication from his legal representative. The hospital waited to hear from the attorney, and in the absence of communication, the case was closed on 1/29/10.

Risk Management stated, during the interview, that once a complainant has retained legal representation, no further communication takes place directly with the complainant. She stated in the past the hospital has been reprimanded by complainant's attorneys for any correspondence directly between the hospital and their client.

Based on the above information, it was determined that the hospital had a grievance

program and was responsive to grievances.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Patients were treated in a rough manner by nursing staff.

Finding #2: One medical record contained documentation related to an elderly female patient admitted to the hospital on 5/14/09, after presenting to a physician's office with a complaint of shortness of breath. She underwent an extensive workup that included multiple laboratory tests, a chest x-ray, a thin-cut resolution computerized tomography scan, an electrocardiogram, and an echocardiogram, and lower extremity doppler ultrasound. Specialists were consulted regarding her care, including cardiology and pulmonology. She passed away, on 5/15/09, before all of the recommended testing and evaluations could be completed.

The Discharge Summary listed several final diagnoses, among them were probable pulmonary emboli (blood clots), deep vein thrombosis (blood clots in the legs), lupus, pulmonary fibrosis, and congestive heart failure.

Nursing documentation revealed that the patient had diminished breath sounds and faint air flow. She was transferred to the telemetry unit for increased monitoring. The patient underwent a doppler ultrasound of the lower extremities while in her hospital bed. She was to have a thoracentesis (draining fluid from the lung cavity) but this was cancelled. There was no indication of rough handling by staff.

The Charge Nurse on duty in the telemetry unit was interviewed. She was also one of the nurses caring for the patient mentioned above. She stated that she recalled the patient and remembered the patient had significant difficulty breathing. She stated she, and the patient's primary nurse, positioned the patient for maximum comfort and ease in breathing. She stated she did not recall any mistreatment of the patient by any of the staff caring for the patient.

Risk Management was interviewed regarding this case, as a grievance had been submitted to the hospital by the patient's spouse. She explained that at the time the hospital became aware of the spouse's concern regarding the patient's care, an investigation was conducted. The medical record was reviewed and then sent through peer review. Numerous staff who worked directly with the patient were interviewed. They did not find evidence that the patient had been mistreated by staff.

Four current patients receiving care on the telemetry unit were interviewed. All of the patients were under the indirect care of the Charge Nurse who worked directly with the patient described above. Each patient was extremely satisfied with their

nursing care and felt they were treated with respect and dignity by hospital staff.

It could not be verified that patients were treated in a rough manner by nursing staff.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

for

AIMEE HASTRITER
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

AH/srp